Children's HOSPITAL • ST. LOUIS
BJC HealthCare

# REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Request Date: _____/_____/_____

Individual Name: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Patient Address: _____

Telephone Number: Home (_____) _____ Work (_____) _____

Medical Record No.: _____

After review of my medical record, I am requesting that information on the following service date(s) _____ be amended/supplemented with certain information and added in the form of an addendum to my medical record. I am requesting this amendment because: _____

_____

_____

I understand that St. Louis Children's Hospital may or may not amend/supplement my medical record based on my request and under no circumstances, can St. Louis Children's Hospital alter the original documentation of my medical record.

Amendment Request:

I request the following amendment/supplement be made to my medical record:

_____

_____

_____

_____

____/____/____ ____:____ _____ _____

DATE TIME SIGNATURE OF **PATIENT *OR*** **PERSON AUTHORIZED TO SIGN/RELATIONSHIP** PRINTED NAME

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?

☐ **Yes** ☐ **No**

**If yes, please specify the name(s) and address(es) of the organization(s) or individual(s):**

_____

_____

_____

_____

**DO NOT WRITE BELOW THIS LINE**

## REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

**For St. Louis Children's Hospital Use Only:**

Amendment has been: ☐ Accepted ☐ Denied

☐ In response to your request, an amendment/supplement will be made part of your medical record.

☐ Your request has been denied for the following reasons:

- ☐ The information is accurate and complete.
- ☐ The information was not created by St. Louis Children's Hospital.
- ☐ The information is not part of the Designated Record Set.
- ☐ Federal law prohibits making the Information available to the patient for inspection (e.g. psychotherapy notes).
- ☐ Other: _____

Staff comments: _____

_____

_____/_____/_____ _____:_____ _____ _____

DATE TIME SIGNATURE OF STAFF PERSON/TITLE PRINTED NAME

**Statement of Disagreement:**

If you do not agree with the above, you may submit a Statement of Disagreement that will become part of your medical record and included in any future disclosure of the subject medical information. Please outline the reason for your disagreement in the space provided below: (may attach no more than 2 pages). Mail to the address listed below.

_____

_____

_____

☐ I do not wish to submit a Statement of Disagreement. However, I am requesting that St. Louis Children's Hospital includes in any future disclosure my request for amendment form and St. Louis Children's Hospital's denial.

_____/_____/_____ _____:_____ _____ _____

DATE TIME SIGNATURE OF **PATIENT *OR*** **PERSON AUTHORIZED TO SIGN/RELATIONSHIP** PRINTED NAME

Forward or mail, postage pre-paid, this form to:

**Health Information Management–Data Integrity**
**BJC Health Care**
**MailStop 90-59-341**
**One Barnes-Jewish Hospital Plaza**
**St. Louis, MO 63110**

**DO NOT WRITE BELOW THIS LINE**